PRINTED: 04/08/2011 FORM APPROVED 0391

The state of the s							
CENTERS FOR MEDICARE & MEDICA	OMB NO. 0938-						
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY				
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED				
	155469	R WING	03/14/2011				

NAME OF	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE / 49TH AVE	
SEBO'S	NURSING AND REHABILITATION CENTER			RT, IN46342	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: March 7, 8, 9, 10, 11 and 14, 2011 Facility number: 000366 Provider number: 155469 AIM number: 100288900 Survey team: Kathleen (Kitty) Vargas, RN, TC Lara Richards, RN Heather Tuttle, RN Janet Adams, RN Census bed type: SNF/NF: 119 Total: 119 Census payor type: Medicare: 16 Medicaid: 95 Other: 8 Total: 119 Stage II Sample: 39 These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed on March 18,	F000	00	Preparation and / or execution of this plan of correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because the provisions of federal and state laws require it. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation for substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

FJN011

Facility ID: 000366

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED 03/14/2011	
	PROVIDER OR SUPPLIER	HABILITATION CENTER	STREET A 4410 W	ADDRESS, CITY, STATE, ZIP CO 4 49TH AVE RT, IN46342	DE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	2011 by Bev Fau	iikner, KIN					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE S	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPL	ETED
		155469	1			03/14/2	011
			B. WIN		ADDRESS STATE STATE STATE		
NAME OF P	ROVIDER OR SUPPLIER	8		l	ADDRESS, CITY, STATE, ZIP CODE		
				l	49TH AVE		
SEBO'S I	NURSING AND REI	HABILITATION CENTER		HOBAF	RT, IN46342		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ind		DEFICIENCY)		DATE
F0156	Based on recor	rd review and interview,	F01	56	F 156 What corrective		04/08/2011
SS=A	the facility faile	d to ensure timely			action(s) will be accomplished	ed	
00 /\	notice was given prior to discontinuing				for those residents found to		
	_	services for 1 of 3			have been affected by the		
	residents review				deficient practice; R 104 is i		
					longer receiving skilled service		
		of skilled services of			since 3/8/11. No corrective ac can be made for this resident.	uon	
		the criteria of being			How the facility will identify		
	•	n skilled nursing			other residents having the		
	services in the	sample of 39.			potential to be affected by th	ا م	
	(Resident #104	!)			same deficient practice and	۱	
	,				what corrective action will be	,	
	Findings includ	le·			taken; All facility residents wi		
	. mamgo moraa				receive skilled services have the		
	On 2/11/11 the	e facility provided a list			potential to be affected by the		
		• •			same deficient practice. The		
		nose skilled services			Admissions Coordinator was in	n	
		ued. Resident #104			serviced on the importance of		
	was listed as h	aving her skilled			ensuring the "Notice of Medica		
	services discor	ntinued on 3/8/11. The			Provider Non-Coverage" form		
	Admissions Co	ordinator provided a			sent to the responsible party a		
		otice of Medicare			least 48 hours prior to the last	day	
	• •	Coverage" form for			of Medicare skilled services.	.	
		. The form indicated			What measures will be put in place or what systemic	10	
					changes will be made to		
		skilled services were to			ensure that the deficient		
	end on 3/8/11.				practice does not recur;		
					Facility Interdisciplinary Team	has	
	There was a re	ceipt for certified mail			been in serviced by the Corpo		
	that was sent to	o the responsible party,			MDS Consultant on beneficiar		
		3/8/11, the same day			notices The facility has	-	
	the skilled serv				designated a back up plan in t	he	
					admissions coordinators abse	nce	
	Whon intoniou	ved on 3/11/11 at 12:30			to ensure that the "Notice of		
					Medicare Provider		
	-	ssions Coordinator,			Non-Coverage" form is sent to		
		ent the responsible			the responsible party at least 4	l β	
	party the "Notic	ce of Medicare Provider			hours prior to the last day of		
					Medicare skilled services. Ho)W	

PRINTED: 04/08/2011 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/14/2011
	PROVIDER OR SUPPLIER	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) the corrective action(s) will be	DATE
	on 3/8/11, the I covered service responsible patimely manner. When interview p.m., the Nurse the responsible 48 hours prior Medicare skille indicated Resid	ved on 3/11/11 at 2:15 e Consultant indicated e party is to be notified to the last day of d services. She dent #104's responsible notified timely of the		the corrective action(s) will be monitored to ensure the defic practice will not recur, i.e., wh quality assurance programs who be put into place; The Administrator/ designee will a residents being discontinued skilled services to ensure time notification has been given. A non-compliance issues the Administrator identifies will be addressed with the admission coordinator. The Administrate /designee will present a summ of the audits to the Quality Assurance committee monthly three months. Thereafter, if determined by the Quality Assurance committee, auditin and monitoring will be done quarterly and present quarter the QA meeting. Monitoring who en going. Date by whis systemic corrections will be completed: April 8,2011	ient iat vill udit from ely iny e is tor nary y for g ly at vill ch

000366

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/14/2011		
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND RE		D. WIIV	STREET A	ADDRESS, CITY, STATE, ZIP CODE 49TH AVE RT, IN46342		
(VA ID CIDALA DV.	TATEMENT OF DEPLOYENCIES					(315)
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E CC	(X5) OMPLETION DATE
F0166 Based on obse	rvation, record review	F01	66		04	4/08/2011
and interviews, ensure a reside documented are the facility's poreviewed for diagonal party of the outgrievance relation of 3 reside personal property for the criteria for the	the facility failed to ent's grievance was and filed according to licy for 1 of 1 residents gnity in the sample of also failed to promptly ent and/or responsible acome/resolution of the ed to missing clothing ents reviewed for arty of the 4 who met bersonal property in the (Residents #19 &			F 166 What corrective action(s) will be accomplished for those residents found to have been affected by th deficient practice? Social Services met with resident #121 to inquire on any concerns thave not been addressed, address new concerns and had documente any such concerns on a grievance form. The family for resident #19 was re-contacted about the missing clothing items, they wish to replathe missing items and bring the receipts in. The facility will reimburse them for the expense.	e hat any d	., 00, 2011
Findings include:				How will you identify other resid	ents	
the Social Service indicated "Our fact their representative member, or appoing grievances or con are made. Any reserves entative (spappointed advoca complaint concert care, behavior of member theft of pof threat or reprise resident, or perso and/or complaint will be informed of investigation and taken to correct at	laints policy provided by Director on 3/8/11, cility will assist resident, ves (sponsors), family nted advocates in filing nplaints when such request			having the potential to be affected the same deficient practice and w corrective action will be taken. All facility residents have the potential to be affected by the alled deficient practice. Review of concern forms showed other open concerns that could be addressed. What measures will be put into ploor what systemic changes you will make to ensure that the deficient practice does not recur? Social Services initiated a plan obringing all concern forms to the daily Interdisciplinary Team meetings. All new and open concerns are reviewed with the II daily until resolution is complete.	no ace I	

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	BER:		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155469	1	LDING		03/14/2	
		100 100	B. WIN			00/11/2	011
NAME OF I	PROVIDER OR SUPPLIER	Ł		1	ADDRESS, CITY, STATE, ZIP CODE		
				1	/ 49TH AVE		
SEBO'S	NURSING AND RE	HABILITATION CENTER		HOBAR	RT, IN46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	nis or her designee, within			Concerns must be addressed with	in 5	
		the filing of the grievance			business days, any concern that		
	or complaint with	the facility."			cannot be addressed in this time		
	4 0 0 0 7 44 11 0 7	10 B			frame will require documentation		
		52 p.m., Resident #121 was			explaining planned resolution to	the	
		da chair in his room. me, with the resident,			concern.		
		en he asks staff something,				\ <u>.</u>	
		tell his aide, but they do not			How will the corrective actions(s	·	
		it or they do not tell the			monitored to ensure the deficient		
		it indicated he feels ignored.			practice will not recur, i.e., what quality assurance program will be	a mut	
		3			into place?	o put	
	The record for Re	sident #121 was reviewed			Concerns are reviewed in each		
	on 3/9/11 at 11:00 a.m. The 12/11/10				morning meeting. Any concerns	not	
		n Data Set (MDS) indicated			resolved within 5 business days v		
		alert and oriented times			be presented to the		
		derstood and was able to			Administrator/DON for resolutio	n.	
	understand. The				A monthly log of concerns and		
	assistance with his	s activities of daily living.			resolution dates will be presented	l to	
	Review of Social S	Service Progress Notes from			the Quality Assurance Committee	e	
		1 indicated there was no			monthly for review. These review	ws	
	_	any behaviors or problems			will remain on-going.		
	with the resident.						
					Date by which systemic		
		Social Service Director on			corrections will be completed i	S	
		m., indicated she has had			4/8/2011.		
		ions with the resident					
		cerns of having to wait a She indicated the resident					
	-	her that he feels he has to					
	•	or care like going back to					
	_	e feels like staff do not pay					
		hen he was talking. She					
		t she has told him to tell staff					
	that you want to la	ay down or to holler at them					
	•	d tell them that you would					
		Further interview indicated					
		locumented any of these					
		aints on a grievance form,					
	nor did she have o	documentation of a					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION	СОМ	(X3) DATE SURVEY COMPLETED	
		155469	B. WING		- 03/14	/2011
NAME OF PROVIDER OF SEBO'S NURSING		HABILITATION CENTER	4410 W	ADDRESS, CITY, STATE, ZIP CO / 49TH AVE RT, IN46342	ODE	
PREFIX (EACE TAG REGUL	I DEFICIEN ATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
with the S indicated complain conversa	Social Se she shou t form an tions she his feeli	resident. Further interview rvice Director at that time, all have filled out a d documented the had with the resident rigs that staff do not pay				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDING COM			(X3) DATE SURVEY COMPLETED
	155469	B. WIN			03/14/2011
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REF		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN46342			
PREFIX (EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
#19 was intervious. She indicated had four sets of was reported to ago. She also in Service Director missing clothing has never receirelated to the lost linterview with the Director on 3/10 indicated she had the dated 12/7/10 the #19's family had articles of missing Review of the for "Concern/Computation of clothing and the service of clothing the service of cloth	orm titled, pliment Form," dated ed the following ing were missing: ece jogging suit ogging suit iece (blank) piece jogging suit	F01	66	F 166 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Social Services met with resident #121 to inquire on any concerns thave not been addressed, address new concerns and had documente any such concerns on a grievance form. The family for resident #19 was re-contacted about the missing clothing items, they wish to replate the missing items and bring the receipts in. The facility will reimburse them for the expense. How will you identify other resident having the potential to be affected the same deficient practice and we corrective action will be taken. All facility residents have the potential to be affected by the alled deficient practice. Review of concern forms showed other open concerns that could be addressed. What measures will be put into ploor what systemic changes you will make to ensure that the deficient practice does not recur? Social Services initiated a plan or bringing all concern forms to the daily Interdisciplinary Team meetings. All new and open concerns are reviewed with the II daily until resolution is complete.	e hat any ed ce ents d by hat egged lano egged lano egged la lano egged la fino egged la fino egged lano egged

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MUL AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO	X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED		
ANDILAN	or connection	155469	A. BUILDING		03/14/2011	
			B. WINGSTREET.	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER		ı	V 49TH AVE		
		HABILITATION CENTER	HOBAF	RT, IN46342		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
TAG	Interview with the Director on 3/10 indicated there of an investigate "Concern/Compared The area on the "Concern/Compared The area on the "Concern/Compared The Solution" was a descripted and the Administrate of the Administrat	he Social Service 0/11 at 10:30 a.m., was no documentation cion documented on the pliment Form." e pliment Form" for as signed by the and was dated 2/16/11. 10/11 at 1:15 p.m. with or who signed the	TAG	Concerns must be addressed with business days, any concern that cannot be addressed in this time frame will require documentation explaining planned resolution to concern. How will the corrective actions (monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be into place? Concerns are reviewed in each morning meeting. Any concerns resolved within 5 business days be presented to the Administrator/DON for resolution A monthly log of concerns and resolution dates will be presente the Quality Assurance Committed monthly for review. These reviewell remain on-going. Date by which systemic corrections will be completed 4/8/2011.	bhin 5 n the s) be t eput s not will on. d to ee eves	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155469	1		03/14/2011		011
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP CODE		
CEDOIC I	NUIDOINO AND DE	LIADII ITATIONI CENTED			/ 49TH AVE		
SEBO S I	NURSING AND RE	HABILITATION CENTER		HOBAR	RT, IN46342		
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TAG		LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
F0241	Based on observation, record review		F02	41	F 241. What corrective action	` '	04/08/2011
SS=E	and interview, the facility failed to				will be accomplished for those		
00 L	ensure the digr	nity of 3 residents in the			residents found to have been	?	
	_	vas maintained during			affected by the deficient practi Residents #14, #45, and #10		
	•	2 meal services			are receiving assistance with t		
	_	sidents #14, #45, and			meals timely. How will you		
	#108)	π i π , π π π π , and			identify other residents having	the	
	#100)				potential to be affected by the		
	The allowant in alread	la.			same deficient practice and wl		
	Findings includ	le:			corrective action will be taken.	All	
					facility residents have the		
		t 12:00 p.m., Resident			potential to be affected by the alleged deficient practice. The		
	#108 was seate	ed in her Broda chair at			facility has implemented and	;	
	a table in the D	aisy Lane dining room.			updated a dining room monitor	r	
	The resident's	lunch tray was placed			schedule to ensure that reside		
	in front of her.	The lid was not			receive and are assisted with		
	removed at this	s time. There were two			their meals properly and timely		
	other residents				The facility has also updated the	he	
		at this time. They			posted mealtime to		
		by two other staff			accommodate maximum staff	.:u	
	_	_			assistance. What measures we be put into place or what system		
	members. At 1	•			changes you will make to ensu		
	•	remained covered in			that the deficient practice does		
		ve staff members were			not recur?Nursing staff will be		
	· ·	dining room and			in-serviced on the importance	of	
	assisting with for	eeding.			promoting care for residents in	n a	
	At 12:16 p.m.,	the resident's tray was			manner and in an environmen	-	
	uncovered and	a staff member started			that maintains or enhances ea		
	to feed her.				resident's dignity and respect if full recognition of his or her	ın	
					individuality with emphasis on:		
	The record for	Resident #108 was			Assisting a resident timely with		
		14/11 at 10:00 a.m.			their meals, i.e. residents seat		
		diagnoses included,			at the same table must be able		
		_			eat together. · Assuring that a		
		nited to, change in			available staff can participate	at	
		history of depression,			meal times. Use of the PA		
	confused, unst	eady gait, dementia,			system to page for available s	ат	
			1				

000366

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	COMP			(X3) DATE SURVEY COMPLETED
		155469	- 1	LDING		03/14/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			1	49TH AVE	
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PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE
		depressive features,			any time addition staff is needed to assure timely assistance. He	
	and vertigo.				will the corrective actions(s) be	
					monitored to ensure the deficie	
	_	Minimum Data Set			practice will not recur, i.e., wha	at
	, ,	ment, dated 12/28/10,			quality assurance program will	
		esident was totally			put into place?Three days a w	
	dependent on s	staff for eating.			the DON/designee will monitor the dining room during rotating meal times to ensure that	
	Interview with 0	CNA #3 on 3/11/11 at			residents receive and are	
		icated the resident was			assisted with their meals prope	erly
	,	dependent on staff to			and timely. The DON/designed	· 1
	be fed.	a a a p a m a a m a a m a a m a a m a a m a a m a a m a a m a a m a a m a a m a a m a a m a a m a a m a a m a a			will present a summary of the	
	50 100.				audits to the Quality Assurance	e
	 Interview with I	PN #2 on 3/11/11 at			committee monthly for three months. Thereafter, if	
		icated the resident had			determined by the QA committ	ree
	to be fed by sta				auditing and monitoring will be	·
	to be led by sta	ш.			done quarterly and presented	at
	Interview with t	he Administrator on			the QA meeting. Monitoring w be on going. Date by which	'III
	3/14/11 at 11:30	0 a.m., indicated the			systemic corrections will be	
		have been assisted			completed: 4/8/2011	
	with her meal ir					
	manner.					

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG		COMPL	ETED
		155469	A. BUII			03/14/2	011
			B. WIN		ADDRESS CITY STATE TINCODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
OEDOIO I	ALLIDOINIO AND DEI	LABILITATION OF NITED			/ 49TH AVE		
SEBUSI	NURSING AND REI	HABILITATION CENTER		HOBAR	RT, IN46342		
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TAG		LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
F0241		ere observed on	F02	41	F 241. What corrective action	` '	04/08/2011
SS=E	3/11/11 at 11:50	0 a.m., in the Rainbow			will be accomplished for those residents found to have been		
-	Room eating lu	nch. There were			affected by the deficient practi	ra 2	
	fourteen reside	nts in the room.			· Residents #14, #45, and #10		
	Twelve residen	ts were eating their			are receiving assistance with t		
		idents were being			meals timely. How will you		
	assisted with fe	_			identify other residents having	the	
		independently feeding			potential to be affected by the		
		esident #14 and			same deficient practice and wl		
					corrective action will be taken.	All	
		were observed sitting			facility residents have the potential to be affected by the		
	•	her. The two residents			alleged deficient practice. The	,	
	had not been s	erved their meals.			facility has implemented and	ĺ	
					updated a dining room monitor	r	
		ervation indicated that			schedule to ensure that reside	nts	
	at 12:05 p.m., t	wo staff members had			receive and are assisted with		
	completed feed	ling two other			their meals properly and timely		
	residents. After	the other residents			The facility has also updated the	ne	
	had completed	their meal, the two			posted mealtime to accommodate maximum staff		
	•	obtained the trays for			assistance. What measures w	/ill	
		nd Resident #45. At			be put into place or what syste		
					changes you will make to ensu		
	-	ff began to feed the			that the deficient practice does		
	•	seventeen minutes			not recur?Nursing staff will be		
		er residents seated in			in-serviced on the importance		
		n had their trays and			promoting care for residents in		
	were eating.				manner and in an environmen		
					that maintains or enhances ea resident's dignity and respect i		
	The record for	Resident #14 was			full recognition of his or her		
	reviewed on 3/	14/11 at 9:05 a.m. The			individuality with emphasis on:		
	Quarterly MDS	(Minimum Data Set)			Assisting a resident timely with	า	
	assessment wi	th an assessment			their meals, i.e. residents seat		
		of 12/21/10 indicated			at the same table must be able		
		is totally dependent on			eat together. · Assuring that a		
		n for eating and that			available staff can participate a	at	
	•	ever is understood and			meal times. · Use of the PA system to page for available si	taff	
	Sile raiely Of He	ever is unucrsidda and			System to page for available s	uii	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPL	ETED
		155469	B. WIN			03/14/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	S.			49TH AVE		
SEBO'S	NURSING AND RE	HABILITATION CENTER			RT, IN46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG			DATE
TAG	rarely or never The resident's 10/7/10, indicated total and daily living due cognitive loss. The record for reviewed on 3/Quarterly MDS reference dated the resident was one staff personalso indicated the short term mentand he was abounderstand and the total term mentand he was abounderstand and the terminant of the resident's 3/11/11, indicated dependent on staff personality living. Interview with Form, on 3/11/1 always fed last linterview with the 3/14/11 at 9:15 staff in the Rain have requested assistance for the staff in the st	plan of care, dated ted the resident ssist with activities of to weakness and Resident #45 was 10/11 8:08 a.m. The with an assessment of 2/19/11 indicated as totally dependent on n for eating, the MDS the resident's long and mory was not impaired te to always dibe understood. plan of care, dated the tresident was staff for activities of Resident #45 at 1:30 1 indicated he is		TAG	any time addition staff is needed to assure timely assistance. How will the corrective actions(s) be monitored to ensure the deficie practice will not recur, i.e., what quality assurance program will put into place? Three days a work the DON/designee will monitor the dining room during rotating meal times to ensure that residents receive and are assisted with their meals proper and timely. The DON/designee will present a summary of the audits to the Quality Assurance committee monthly for three months. Thereafter, if determined by the QA committee done quarterly and presented the QA meeting. Monitoring will be done quarterly and presented the QA meeting. Monitoring will be completed: 4/8/2011	ed ow e ent at be eek d erly e	DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155469			(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	COM	(X3) DATE SURVEY COMPLETED 03/14/2011		
	PROVIDER OR SUPPLIER	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN46342					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	should have be in a more timel	een assisted with eating y manner.						
	3.1-3(t)							

STATEMENT OF DEFICIENCIES X1) PROVIDER		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		nn.a		COMPL	ETED
		155469	A. BUII			03/14/2	011
			B. WIN		ADDRESS CITY STATE ZIR CODE		
NAME OF P	ROVIDER OR SUPPLIER	-		l	ADDRESS, CITY, STATE, ZIP CODE		
				l	/ 49TH AVE		
SEBO'S I	NURSING AND REI	HABILITATION CENTER		HOBAF	RT, IN46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΤE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
F0244	Based on interv	view and record review,	F02	44	F 244 What corrective action		04/08/2011
SS=C	the facility failed	d to ensure the			will be accomplished for thos		
00-0	residents were aware that their suggestions and recommendations				residents found to have beer	ו	
					affected by the deficient		
	• •	rules of the facility			practice; The facility held an		
	_	•			emergency resident council	.~	
		d at anytime for 1 of 1			meeting on 3/24/2011 informing the residents that their	ıy	
	Resident Coun				suggestions and		
		s had the potential to			recommendations concerning	the	
	affect 119 resid	ents who resided in			rules of the facility could be		
	the facility.				voiced at any time. The reside	nt	
					council president is currently in		
	Findings include:				the hospital, upon readmissior	n an	
					additional meeting may be hel	d.	
	_	ew with the Resident			How the facility will identify		
		on 3/9/11 at 2:00 p.m., the			other residents having the		
		d he did not know and			potential to be affected by th	е	
		y answer if he was aware			same deficient practice and		
		d make suggestions about cility and if the facility			what corrective action will be		
	would act on these				taken; All facility residents ha		
	modia dot on thos				the potential to be affected by	the	
	Review of the Res	ident Council Meeting			same alleged deficient	la a	
		indicated there had not			practice. What measures will put into place or what system		
	been information p	provided to the residents,			1	IIIC	
	during the meeting	gs, related to the rules of the			changes will be made to ensure that the deficient		
	facility.				practice does not recur; The	,	
					facility will add to the agenda f		
		Activity Director, on 3/9/11			the next resident council meet		
	• •	ated she has not discussed			and the next scheduled family	•	
		tings information regarding			meeting imforming residents a		
		ns about the rules of the gany of the rules in the			families that the facility will list		
	, ,	e documented any type of			to the views and act upon the		
	that information.	o accumented any type of			grievances and recommendati	ions	
	ulat information.				of residents and families		
	Interview with the Administrator, on 3/10/11				concerning proposed policy ar		
	at 12:45 p.m., indicated there was no			operational decisions affecting			
	documentation regarding the residents being				resident care and life in the		
		could make suggestions			facility. How the corrective		
			1		action will be monitored to		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION	COMP	COMPLETED	
		155469	B. WING		03/14/2	:011
	PROVIDER OR SUPPLIER	HABILITATION CENTER	4410 W	ADDRESS, CITY, STATE, ZIP COE V 49TH AVE RT, IN46342	DE .	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
IAU	about the rules in 3.1-3(I)	· · · · · · · · · · · · · · · · · · ·	IAU	ensure the deficient prawill not recur, i.e. what assurance programs winto place; The Administrator/Designee monitor resident council to ensure the concerns a responded to/resolved in manner. In addition grougrievance/recommendat remain on the agenda of resident council meeting Administrator/designee vandomly interview 5 resevery week to determine knowledge of the group grievance/recommendat process, additional inform will be provided to any reunaware. The Administrator/designeent a summary of in results to the Quality Assommittee monthly for siconsecutive months or use compliance is met. Date which systemic correct be completed by 4/8/20	actice quality ill be put will concerns are n a timely p ion will f the . The will idents there ion mation esident hee will terview surance ix intil e by ions will	DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155469	1			03/14/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	₹					
SEBO'S	NI IDSING AND DE	HABILITATION CENTER		4410 W 49TH AVE HOBART, IN46342			
SEBO 3	NORSING AND RE	HABILITATION CENTER		HOBAR			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG			DATE
F0250	Based on o	bservation,	F02	50	F 250 What corrective action(s) will be accomplished	ed	04/08/2011
SS=D	record revie	ew, and			for those residents found to		
	interviews,	the facility failed			have been affected by the deficient practice; R 121 wa	ne l	
	to provide r	nedically-related			seen by the oral surgeon on		
	· •	ces related to not			3/16/2011 for treatment. Medic clearance was obtained at the		
	arranging fo	or the medical			time. How the facility will		
					identify other residents havi	ng	
	clearance r	equired for oral			the potential to be affected b	-	
	surgery for	1 of 1 residents			the same deficient practice a what corrective action will be		
	reviewed for	or dental services			taken; All facility residents		
	in the samp	ale of 30			referred for oral surgery have	the	
					potential to be affected by the		
	Resident #	‡ 121)			same alleged deficient practic An audit of residents that were		
	Findings include:				seen by the dentist since 1/1/2		
	i manigs merade.				was completed to ensure that		
	Interview with Res	sident #121 on 3/7/11 at			recommendations are comple		
	3:06 p.m., indicate	ed his gums were sore			and any resident referred for o		
		epending on what was			surgery has medical clearance		
		ad some difficultly chewing			What measures will be put in	ito	
	his food, due to no	ot having a lot of teeth.			place or what systemic changes will be made to		
	On 3/7/11 at 3:16 r	o.m., Resident #121 was			ensure that the deficient		
	-	n a Broda chair in his room.			practice does not recur; Th	e	
	_	esident's teeth were			Social Service Department an		
	·	cayed, chipped and			clinical staff were in-serviced		
		lent was missing many of			4/1/2011 regarding:		
	his teeth.				Obtaining medical clearance		
					timely for residents requiring of	oral	
		sident #121 was reviewed			surgery.		
		a.m. The resident's			Dental recommendations		
	_	ed, but were but not limited			Oral surgery referrals and		
	diabetes.	cirrhosis of the liver, and			follow-up. How the corrective action(s	,	
					will be monitored to ensure the	·	
	Review of the 4/6/	10 initial Minimum Data Set			deficient practice will not recui	-	
	(MDS) assessmen	t indicated the resident			i.e., what quality assurance	<i>'</i>	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
ANDILAN	or correction	155469	A. BUI			03/14/20		
		.00.00	B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER				49TH AVE			
SEBO'S	NURSING AND REI	HABILITATION CENTER		1	RT, IN46342			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
	*				CROSS-REFERENCED TO THE APPROPRIAT	E		
PREFIX TAG	was alert and orienable to understand. The MDS indicated natural teeth lost a dentures. The rescarious teeth and was provided by some teeth and up indicated the broken, loose The care plan resident will resident	ident has broken, loose, or daily cleaning of his teeth taff or the resident. blan of care, dated odated on 12/11/10, resident has a concarious teeth. In goal was that the not experience decay. The nursing were to assess the bral cavity, teeth, provide staff or oral hygiene, and cal consult. be Dentist's visit initial visit was on a Dentist and for the resident to		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE	ntal ne sed. will its	COMPLETION DATE	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155469		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/14/2011	
	PROVIDER OR SUPPLIER	HABILITATION CENTER	STREET. 4410 V	ADDRESS, CITY, STATE, ZIP CODE V 49TH AVE RT, IN46342	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	to see oral su and evaluation	urgeon for X-ray on.			
	the oral surge however, he surgeon on the appointment for 7/27/10. ADON (Assist Nursing) on 3 indicated she the resident of surgeon on the surgeon on the facility of the facility of therefore, howith the oral canceled. The next de 8/9/10 and	set up and went to eon on 7/15/10, did not see the hat day and his was rescheduled Interview with the tant Director of 3/11/11 at 9:00 a.m., e did not know why did not see the oral hat day. In the was admitted ital on 7/23/10 admitted back to on 7/27/10, his appointment all surgeon was ental visit was on			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE		
		155469	A. BU B. WI			03/14/2	2011
NAME OF F	PROVIDER OR SUPPLIER		_		DDRESS, CITY, STATE, ZIP CODE		
SEBO'S	NURSING AND REI	HABILITATION CENTER			49TH AVE T, IN46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE	(X5) COMPLETION DATE
	surgeon an	d also indicated t had					
		nt with the oral					
	surgeon on waiting on recemment for the residual with the ora	rom his primary The dentist then ded on 8/24/10 dent to follow up all surgeon. ith the ADoN on					
	indicated al information oral surgeo the surgeor facility withi	I of the resident's was faxed to the n on 8/24/10 and n would call the n three days. the oral surgeon abs be obtained					
	•	dent. On 9/13/10,					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
ANDILAN	or connection	155469		LDING		03/14/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	49TH AVE		
SEBO'S	NURSING AND REI	HABILITATION CENTER		HOBAR	RT, IN46342		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	.	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		ted laboratory					
work for surgery was faxed							
	to the oral s	•					
	The Dentist	saw the resident					
		and 10/18/10					
	-	ed the resident					
		seen the oral					
	surgeon an						
		dation to see the					
		n, and that the					
	dentist reco	ommends					
	extraction c	of all teeth.					
	-	the Dentist saw the					
		again indicated the					
		had not gone out					
	1	ery. The Dentist					
	·	tient states he					
		th out and to get					
		he next Dental visit 11 which indicated					
		does plan to go out					
	· ·	rgeon." The last					
		as on 3/3/11, and					
		ked to Social					
		ne) today and					

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMP	(X3) DATE SURVEY COMPLETED 03/14/2011	
		155469	B. WIN		ADDRESS OF VICTATE ZID CODE		2011	
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE ' 49TH AVE			
SEBO'S	NURSING AND RE	EHABILITATION CENTER		HOBAR	RT, IN46342			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL		(X5)	
PREFIX TAG	.	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETION DATE	
	patient has r	not gone out to oral						
	surgeon. Di	d not see patient						
	today."							
		vith the Social						
		ector on 3/10/11						
		n., indicated she						
	had spokei	n to nursing staff						
	a couple w	eeks ago, and						
	they were v	waiting for the						
	doctor to si	ign a medical						
	clearance t	to get the surgery						
	done. She	indicated the						
	resident ne	eds to have his						
	teeth surgi	cally removed.						
	Review of	Social Service						
	Progress n	otes, dated						
	•	, indicated there						
		cumentation or						
		ation regarding						
	1 -	rgeon and the						
		e resident's teeth						
	to be extra							
	ן נט טפ פאנומי	olou.						
	Review of	Nurse's Notes,						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155469		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED 03/14/2011	
	PROVIDER OR SUPPLIER	HABILITATION CENTER	STREET A 4410 W	ADDRESS, CITY, STATE, ZIP COI / 49TH AVE RT, IN46342	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	there was ror information resident's note to be extracted to see the continuous manner. Interview was 3/11/11 at 9	ol-3/11, indicated no documentation on regarding the need for his teeth and the need oral surgeon. ith the ADoN on 0:00 a.m.,				
	Oral Surged speak to the primary phy medical cle surgery. The indicated at nursing star followed up recommend need for the	on was waiting to e resident's /sician to obtain arance for ne ADoN further t the time, that ff should have with the dentist's dations and the e resident to see geon so his teeth				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155469		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED 03/14/2011			
SEBO'S N		HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN46342					
	NURSING AND RE SUMMARY S (EACH DEFICIEN		4410 W	/ 49TH AVE	RECTION OULD BE	(X5) COMPLETION DATE		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIEF		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		COMPL	ETED
		155469	B. WING			03/14/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				/ 49TH AVE		
SEBO'S I	NURSING AND REI	HABILITATION CENTER	HOBART, IN46342				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	<u> </u>		(V5)
PREFIX				PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
F0253		rvation and interview,	F02:		F253 What corrective actions	<u> </u>	04/08/2011
		•	1.02.))	will be accomplished for thos	-	04/08/2011
SS=E	the facility failed				residents found to have been		
		onment was clean and			affected by the deficient		
	•	elated to marred			practice. Apple Lane The		
		valls, marred bathroom			spillage in the ceiling in room 2	20	
	walls, rusty ceil	ing vents, discolored			was cleaned.The shower room	n on	
	floor tile grout,	gouged and marred			Apple lane had the following		
	furniture and oc	dors in resident rooms			corrections made. The stains		
	for 5 of 5 hallwa	ays. This affected 34			the bathtub were cleaned The ceiling light bulbs were replace		
	residents in the	population of 119			The foot section of the wall tile		
		ng in 18 of 71 rooms,			the column in the second stall	011	
	with the potenti	•			was repaired. The dried ceme	ent	
	•	ived in the facility.			on the wall in the third stall wa		
					removed_ Therapy A therapy to	able	
	` •	akersfield, Apple Lane,			has been ordered to replace the		
	•	lueberry Lane, and			high-low table. Beauty Shop A	١.	
	Cherry Court)				quote has been accepted to		
	-	21, 23, 24, 29, 30, 4,			replace the floor tile. The dryer heads in the beauty shop were		
	70, 33, 41, 44,	45, 47, 48, 50, 52, 57)			cleaned. <u>Bakersfield</u> The chai		
					identified as marred and scuffe		
	Findings include:				in the dining room were		
	The fellowing was				painted.The splash guard on tl	he	
	-	observed during the ur on 3/11/11 at 11:30 a.m.,			soiled utility door was		
	on Apple Lane:	31 OH 3/11/11 at 11.30 a.m.,			cleaned.The furniture in the		
					activity room was painted. The		
	a. The resident ro	om walls were marred and			wood cabinets in the activity ro	oom	
	discolored in Room	ms 19, 20, 21, 23, and 24.			were painted. The toilet paper roller in room 70 was replaced		
		sidents in each of those			Blueberry Lane The bathroom		
	-	Room 24 where only one			room 41 was cleaned to remove		
	resident resided.				the odor. Daisy Lane The dini		
	h Thodosefess	s was marred in Rooms 21			room chairs have been	-	
		ents resided in Rooms 21			replaced.The furniture in the		
	those rooms	onto resided in Eden Of			dining room has been cleaned		
					and painted. The floor register		
	c. The ceiling had spillage observed on it in			was painted. The ceiling vent in the hallway was painted. The	1		
Room 20. Two residents resided in this				grout in the floor tile was clean	ed		
	room.				grout in the hoof the was clear		
					l		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING		COMPL	ETED
		155469	B. WIN			03/14/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	8			/ 49TH AVE		
CEDOIC		LIADII ITATIONI CENTED		I			
SEBO S	NURSING AND RE	HABILITATION CENTER		HOBAR	RT, IN46342		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	burned out. The shower room was of wall tile on the conted on the wall sides of the hallway. The following was court during the E 3/11/11 at 11:00 a The wallpaper of	vas observed on Cherry Environmental Tour on m.: on both sides of the hall			rooms 45 and 50 were repaired/repainted. Rainbow Room The chairs that were marred and scuffed were repaired. A contractor has be secured to repair/repaint resid rooms and/or bathroom walls froom #'s 4, 19, 20, 21, 23, 24 29,30, 33, 41, 44, 45, 47, 48, 52, 57; repaint/refinish doors and/or door frames for resider rooms, 21, 24, 44, 50, 52, 57 common areas of the beauty shop, Bakersfield dining room	ent of , 50, ut and	
		re torn below the chair rail			and activity room; repair/paint		
	throughout the en	tire hallway.			chapel; remove the wallpaper repair/paint the walls in the	and	
	h The resident re	oom walls and bathroom			beauty shop, Rainbow dining		
		I in Rooms 29, and 30.			room, hallways on Apple Lane		
		sidents who resided in			Cherry Court, Cherry Lane,	,	
		resident resided in room			Blueberry Lane, Bakersfield a	nd	
	30.				Daisy Lane; repair/paint the		
					walls/ceiling in the Rainbow		
		vas observed on Cherry			dining room; replace the wall		
	Lane during the E	nvironmental Tour on			guard at the Bakersfield nurse	s	
	3/11/11 at 11:00 a.ı	m.:			station, repaint the ceiling ven		
					on Daisy Lane, Bakersfield, ar		
		behind the resident's bed			the beauty shop. A contractor		
		4. The resident room			has been secured to replace the		
		arred. There were two			flooring in the beauty shop Ne		
	residents who res	iaea in this room.			chairs and furniture have beer ordered for the Daisy dining	1	
	b . The wallpaper of	on both sides of the hall had			room, Bakersfield dining room	,	
	areas below the chair rail that were torn and				Bakersfield activity room, and		
	dingy throughout t				Rainbow dining room. How the		
		•			facility will identify other		
	•	able mats were torn. The			residents having the potentia	al	
	-	in the therapy room were			to be affected by the same		
	marred and scrato	ched.			deficient practice and what		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155469	B. WIN			03/14/2	011
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
					/ 49TH AVE		
		HABILITATION CENTER			RT, IN46342		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ГЕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	<u> </u>		DATE
	d. All the walls we	ere marred in the Chapel.			corrective action(s) will be taken. All facility residents ha the potential to be affected by		
	e. The Beauty Sh	op floor tile was chipped			deficiency. Housekeeping and		
		roximately two foot sections.			Maintenance have been		
		as buckling on the walls and			re-educated and in-serviced		
		rred. The ceiling vent dusty			regarding this deficiency. What		
		four dryer heads were sticky			measures will be put into pla		
	•	or frame was marred			or what systemic changes w	ill	
	gouged.				be made to ensure that the		
	4 The fellowing o	use absenced on			deficient practice does not		
	4. The following v	y the Environmental Tour			recur. The maintenance and		
	on 3/11/11 at 11:00	_			housekeeping director/designe		
	011 0/11/11 at 11:00	, 4			will complete rounds two times	3	
	a. The Nurses St	ation was missing the wall			every week to ensure that the		
		s walls. The ceiling vent in			facility environment is maintain	nea	
	the hallway was ru				in a sanitary, orderly, and comfortable interior. The		
	,	,			Maintenance Inspection Check	kliet	
	b. The outside of	the dining room door was			and Housekeeping Daily Clear		
		nately 20 dining room chairs			Schedule will be completed wi		
		scuffed. All the walls were			rounds twice weekly. How the		
		chipped below the chair rail.			corrective action(s) will be		
	The ceiling vent w	as rusty.			monitored to ensure the		
					deficient practice will not rec	ur,	
		ard was dirty on the soiled			i.e. what quality assurance		
	utility room door.				programs will be put into pla	ce.	
	d The furniture in	n the activity room was			The Administrator/designee v		
		ed. The three wood cabinets			present a summary of audit		
		scuffed. The ceiling vent			findings to the Q/A committee		
		door frame was in need of			monthly for review for three		
	painting.				months and until compliance is		
					met. Date by which systemi		
	e. The toilet pape	er holder was missing in the			corrections will be completed	d	
	Room 70. There	were two residents who			is 4/8/2011.		
	resided in this roo	m.					
		vas observed during the					
	Environmental Tour on 3/11/11 at 11:00 a.m.,						
	on Blueberry Lane	e:					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMP	LETED	
		155469	B. WING		— 03/14/2	2011	
				TADDRESS, CITY, STATE, ZIP C	ODE		
NAME OF P	PROVIDER OR SUPPLIER		l	W 49TH AVE			
SEBO'S I	NURSING AND REI	HABILITATION CENTER		RT, IN46342			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE	
TAG	a. The resident ar marred in Rooms residents who resides of the entire torn. c. There was an use of Room 41. There ided in this room 6. The following we Environmental Tou on the Daisy Lane and the Daily Lane din room chairs were the Daily Lane din room chairs were scuffed. The furnistand) in the dining and marred and in register was marred. The ceiling ven d. The resident ar were marred in Roand 57. The ground resident bathroom were two residents these rooms.	and bathroom walls were 33 and 41. There were two ided in these rooms. below the chair rail on both hallway was discolored and wrine odor in the bathroom re were two residents who m. was observed during the part on 3/11/11 at 11:00 a.m. marred below the chair rail rail rail re entire hallway. marred and discolored in rail room was dirty, scuffed and ture (the cabinets and two groom was dirty, scuffed a need of repair. The floor red. t was rusty in the hallway. and bathroom room walls rooms 44, 45, 47, 48, 50, 52, ton the floor tile in the say was discolored. There is who resided in each of	TAG	CROSS-REFERENCED TO THE ADEPTICIENCY)	APPROPRIATE	DATE	
	were marred in Ro	closet, and room doors ooms 57, 44, 50, and 52. sidents who resided in each					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION	li i	E SURVEY LETED	
		155469	A. BUILDING B. WING		03/14/	
NAME OF F	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CO	DDE	
SEBO'S	NURSING AND REI	HABILITATION CENTER		V 49TH AVE RT, IN46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORI	PECTION	(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	COMPLETION DATE
IAU		· · · · · · · · · · · · · · · · · · ·	IAU			DATE
		were marred and scuffed in There were two residents				
	who resided in eac					
		marred below the chair rail				
		oom. There were four chairs and scuffed. There was a				
		the ceiling that was water t was also noted to be				
		reas. The door frame was				
		Maintenance Director on .m., indicated all the above				
	was in need of rep	pair or cleaning.				
	3.1-19(f)					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/14/2011		
	PROVIDER OR SUPPLIER	HABILITATION CENTER		STREET A	ADDRESS, CITY, STATE, ZIP CODE / 49TH AVE RT, IN46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
F0280 SS=D	Based on obse and interview, to ensure the plant revised to reflect 2 of 26 resident were reviewed related to splint catheter remove (Residents #42). Findings Included 1. On 3/8/11 at p.m., Resident her in room in the right hand was left arm was until The resident displace to her right place to her right hand and the resunderneath the p.m., the resident wheelchair in her did not have an place.	rvation, record review he facility failed to of care had been at the current status of its whose care plans in the sample of 39 application or Foley al. and #121) e: 1:45 p.m. and 3:42 #42 was observed in bed. The resident's closed in a fist and her derneath the blanket. In and the control of the cont	F02		F 280 What corrective action will be accomplished for thos residents found to have been affected by the deficient practice; The care plan for R has been updated to address resident removing her splints. addition the resident and the family have been educated regarding the risks associated with removing and failing to we splints. The care plan was updated for R121 to address the resident's refusal to remove the foley catheter. In addition the physician has updated his progress notes to reflect the resident's refusal of the foley catheter. How the facility will identify other residents having the potential to be affected by the same deficient practice as what corrective action will be taken; All facility residents requiring splint application or removal of a foley catheter have the potential to be affected by same alleged deficient practice. The interdisciplinary of plan team was re-inserviced by the MDS/Care Plan Consultant 3/29/2011 with an emphasis gion the importance of ensuring residents' plan of care is updated and reflective of: 1. The residents' refusal of required splint application and associated risks. The residents' refusal to remove a foley catheter and associated risks.	se 1.42 the In ear he e 1.7 the ear he e	04/08/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DINC		COMPLETED	
		155469	B. WING			03/14/2011	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	L		l	/ 49TH AVE		
SEBO'S	NURSING AND RE	HABILITATION CENTER		· ·	RT, IN46342		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	E	PLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	D	ATE
	The plan of car	e, dated 1/17/11,			Review of physician progress	.	
	indicated the re	esident required			notes to include documentatio	n of	
	splint/brace ass	sistance to her			resident refusal.		
	bilateral hands	6-7 times per week.			What measures will be put into place or what systemic		
					changes will be made to		
	The intervention	ns indicated the			ensure that the deficient		
		ns malcated the			practice does not recur; The	_	
	following:				Restorative Nurse/designee w		
					audit the restorative		
	Monitor for pres	•			documentation sheets weekly	to	
	intolerance, or	muscle spasm during			ensure that information		
	range of motior	٦.			documented by the restorative	:	
					CNA such as splint refusals is		
	Provide passive	e range of motion to			updated in the resident's care		
	bilateral hands	•			plan and education regarding	:he	
		times per week.			risks of splint refusal is		
		tilles per week.			alsoincluded. The		
					DON/designee will audit telephone orders that indicate		
		lateral hands on in			discontinuation of the foley		
	A.M. off in P.M	. 6-7 times per week.			catheter. In the event the resid	lent	
					refuses to remove the foley		
	Inspect skin to	bilateral hands prior to			catheter the care plan will be		
	each applicatio	n and after each			updated which will include the	risk	
	1	nts 6-7 times a week.			of prolonged use and the		
		eport any red or broken			physician progress notes will be	e	
		Sport any red or broken			reviewed to ensure		
	areas.				documentation is in place. He)W	
	l				the corrective action(s) will be		
		Restorative CNA #1 on			monitored to ensure the defici		
	3/9/11 at 3:30 p	o.m., indicated the			practice will not recur, i.e., who	l l	
	resident has a	history of removing her			be put into place; The Restora		
	splints shortly a	after they are applied.			nurse/designee will present a		
		icated when the			summary of the restorative		
		es her splints that she			documentation sheet audit to	he	
		t information on the			Q/A committee monthly for six		
					consecutive months and then		
	back of the res	iorative sneet.			ongoing until compliance is m		
					The DON/designee will preser	ıt a	

Facility ID:

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			LETED
		155469	B. WING		03/14/2	2011
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	-	
				V 49TH AVE		
SEBO'S	NURSING AND RE	HABILITATION CENTER	HOBA	RT, IN46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT.	ON	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO) BE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
		current plan of care did		report summary of audit fir		
	not address the	e resident removing her		related to the refusal to rel discontinued foley cathete		
	splints.			review of physician progre		
				notes to the Q/A committe		
	The resident ca	are card indicated		monthly for six consecutive		
	bilateral resting	hand splints were to		months and then ongoing		
	be used and th	ey were to be applied		compliance is met. Date b which systemic correction	-	
	in the a.m. and	removed in the p.m.		be completed: 4/8/2011	IIS WIII	
	Documentation	on the care card		23 3511pistodi 1/0/2011		
	indicated the re	esident frequently				
	removed the sp	olints and they were to				
	be reapplied as	s needed.				
	Interview with t	he Restorative Nurse				
	on 3/9/11 at 3:3	35 p.m., indicated the				
	resident contin	uously takes off her				
	splints. Furthe	er interview at 4:23				
	p.m., indicated	the resident's current				
	care plan did n	ot address the resident				
	taking off her s	plints and the care plan				
	needed to be u	pdated.				

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE S	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG		COMPL	ETED
		155469	A. BUII			03/14/2	011
			B. WIN		ADDRESS CITY STATE TINCODE		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
CEDOIC I	ALLIDOINIO AND DEI	LIADU ITATION CENTED		l	/ 49TH AVE		
SEBO S I	NURSING AND REI	HABILITATION CENTER		HOBAR	RT, IN46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	CROSS-REFERENCED TO T		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0280	2. Resident #1	21 was observed on	F02	80	F 280 What corrective action	` ′	04/08/2011
SS=D	3/9/11 at 2 p.m	. The resident was			will be accomplished for thos		
00-0	seated in a Bro	da chair, the resident			residents found to have beer	י	
	had a Foley ca				affected by the deficient		
	nad a roloy oa				practice; The care plan for R		
	The record for	Decident #121 was			has been updated to address		
		Resident #121 was			resident removing her splints. addition the resident and the	""	
		9/11 at 11:00 a.m. The			family have been educated		
	_	noses included, but			regarding the risks associated		
		d to, kidney failure and			with removing and failing to we		
	history of prost	ate surgery.			splints. The care plan was		
					updated for R121 to address t	he	
	Physician orde	rs, dated 8/24/10,			resident's refusal to remove th	е	
	•	continue the Foley			foley catheter. In addition the		
		ew of Nurse's Notes,			physician has updated his		
		indicated the resident			progress notes to reflect the		
		al of the Foley catheter.			resident's refusal of the foley catheter. How the facility will		
		· · · · · · · · · · · · · · · · · · ·			identify other residents havir		
		of nursing progress			the potential to be affected b	-	
		I the resident was			the same deficient practice a	-	
	•	consequences of			what corrective action will be		
	keeping the Fo	ley catheter. On			taken; All facility residents		
	8/25/10, the res	sident's physician was			requiring splint application or		
	notified of the r	esident's refusal of			removal of a foley catheter have	ve	
	discontinuing th	ne Foley catheter.			the potential to be affected by	the	
	J	-			same alleged deficient		
	Review of Phys	sician Progress Notes,			practice.The interdisciplinary of		
	•	1, indicated there was			plan team was re-inserviced b the MDS/Care Plan Consultan	-	
		ion of the resident's			3/29/2011 with an emphasis gi		
					on the importance of ensuring		
	refusal of the F	oley cameter.			residents' plan of care is upda		
					and reflective of: 1. The		
		n of care, updated on			residents' refusal of required		
	12/23/10, indicate	ated the resident			splint application and associat	ed	
	requires an ind	welling Foley catheter			risks.		
	related to diagr	noses (dx): (blank).			The residents' refusal to remove		
	_	proaches were to			a foley catheter and associate	a	
					risks.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155469	B. WIN			03/14/201	1
	PROVIDER OR SUPPLIER	HABILITATION CENTER		4410 W	ADDRESS, CITY, STATE, ZIP CODE / 49TH AVE RT, IN46342		
	SUMMARY S' (EACH DEFICIENCE REGULATORY OR ASSESS drainage color, odor, and Nursing staff we tract infection seatheter per phe position bag be a seighbor of the care plan of the			4410 W	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Review of physician progress notes to include documentation resident refusal. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The Restorative Nurse/designee we audit the restorative documentation sheets weekly ensure that information documented by the restorative CNA such as splint refusals is updated in the resident's care plan and education regarding risks of splint refusal is alsoincluded. The DON/designee will audit telephone orders that indicate discontinuation of the foley catheter. In the event the resident's care refuses to remove the foley catheter the care plan will be updated which will include the of prolonged use and the physician progress notes will be reviewed to ensure documentation is in place. He the corrective action(s) will be monitored to ensure the deficie practice will not recur, i.e., who quality assurance programs we be put into place; The Restoral nurse/designee will present a summary of the restorative documentation sheet audit to the documentation she	n of etill to the the ent tive he	(X5) COMPLETION DATE
					Q/A committee monthly for six consecutive months and then ongoing until compliance is me The DON/designee will preser	et.	

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG		COMPLETED	
		155469	A. BUII			03/14/2	011
			B. WIN				
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
				1	49TH AVE		
		HABILITATION CENTER			RT, IN46342		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
					report summary of audit findin- related to the refusal to remov discontinued foley catheter an review of physician progress notes to the Q/A committee monthly for six consecutive months and then ongoing until	e a d	
					compliance is met. Date by		
					which systemic corrections	will	
					be completed: 4/8/2011		
					•		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		155469		B. WING			03/14/2011	
			STREET ADDRESS, CITY, STATE, ZIP CODE					
NAME OF P	ROVIDER OR SUPPLIER		4410 W 49TH AVE					
SEBO'S NURSING AND REHABILITATION CENTER				HOBART, IN46342				
				TIODAI				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX				COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG				DATE	
F0282	Based on observation, record review,		F0282		F282 What corrective		04/08/2011	
SS=D and interviews,		, the facility failed to			action(s) will be accomplished for those residents found to have been affected by the deficient practice; The TED			
	ensure Physician orders were							
	followed as written related to							
	antiembolytic stockings (TED hose)							
	and the application of a PRAFO boot.				hose stocking for R121 were discontinued on 3/11/2011. Th			
	1		l		physicians order for the PRAF			
	The facility also failed to follow the			boots for R121 was clarified				
	resident's plan of care related to				/14/2011. PRAFO boots are to			
	providing oral care and ensuring				be worn when resident is			
	documentation of skin integrity for 1 of				transferred out of bed and is up in			
	3 residents reviewed for Activities of				the Broda chair. The abrasions	abrasions to		
	Daily Living (ADL) care of the 9		R121 face sustained while					
	residents who met the criteria for ADL		shaving himself are resolved.					
	care in the sample of 39. (Resident			R121 is receiving routine set up				
	#121)			for oral care. How the facility				
	#121)				will identify other residents			
	Francisco de la				having the potential to be			
	Findings include:				affected by the same deficient			
	On 3/7/11 at 3:07	n m. during an interview			practice and what corrective action will be taken; All facility			
	On 3/7/11 at 3:07 p.m., during an interview with Resident #121, he indicated that staff do			residents have the potential to be		-		
	not provide oral care for him. He indicated				effected by the same alleged			
	there was a toothbrush in the drawer, but no			deficient practice. The facility has				
	one helps him. He also indicated at the time,		identified all resident with					
	they have the sponge swabs, but no one gives				physician orders for TED hose			
	him those to use, he said, "The toothbrush				The facility has identified all resident with physician orders for PRAFO boots. All residents are identified as having the potential to have altered skin integrity. All residents are identified as			
	hurts my teeth sometimes." Further interview							
	with the resident, indicated he does not							
	remember the last time, any staff member or							
	himself brushed his teeth. He said, "It was a							
	long time ago." The resident further indicated that he not been offered mouthwash either. At that time, the resident was observed sitting							
						uiring oral care. Nursing staff been re-inserviced by NADON regarding the		
					DON/ADON regarding the			
	in a Broda chair in his room. The resident's		following:					
	teeth were noted to be discolored, decayed				Following the physician orders	cian orders for		
		resident had many missing			TED hose and PRAFO boots	* ·		
		nt was also observed with			Completion of oral care daily for	or		
	scratches and abr	asions to his chin area and			all residents and providing			

000366

AND PLAN OF CORRECTIO		IDENTIFICATION NUMBER:					
			A DITE	LDING		COMPLETED	
		155469	B. WIN			03/14/2	011
		<u> </u>	D. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR S	PPLIEI	₹			/ 49TH AVE		
SEBO'S NURSING A	D RE	HABILITATION CENTER			RT, IN46342		
(X4) ID SUM	IARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX (EACH D	FICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG REGULAT	RY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
lower cheet time, they was a brought into wearing blawere no TE noted to be abrasions to lower cheed observed to the care or before the care or be	s. There for 2:15 the north should be decay the he should be decay the bed at the should be decay the bed do not a second pin a second pin a second pin a second pin a second be decay the bed do not t				assistance if needed. Notification to the charge nurs and physician for any resident with altered skin integrity. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The DON/designee will conduct rounds 3x/weekly to observe to physician orders are being followed for residents identified with TED hose and PRAFO boots, in addition the DON will observe for alterations in skin integrity (such as abrasions for shaving) to ensure the charge nurse and physician have been notified and the skin condition addressed. The DON/designee will complete random interview with 7 residents weekly to ensure that oral care is being complet and assistance is provided who needed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be into place; The DON will present a summary of interview finding to the Q/A committee monthly six consecutive months and the ongoing until compliance is more than the poon of the place into place; The poon will present the poon of the poon of the poon of the poon of the place into place; The poon will present the poon of	e hat d l om e n is e vs ure ed en t gs for ien et. at a	
brush his to CNA also in	eth ar dicate	m a toothbrush or paste to ad he indicated "no." The ad at the time, that she has toothbrush or the paste so			summary of observational rou findings to the Q/A committee monthly for six consecutive months and ongoing until compliance is met. Date by	iiu	

PRINTED: 04/08/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		155469	B. WING		03/14/2	2011
	PROVIDER OR SUPPLIER	HABILITATION CENTER	4410 W	ADDRESS, CITY, STATE, ZIP CODE V 49TH AVE RT, IN46342	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
	he could brush his bad teeth." The re in the bed during to indicated that he has to be set up to remember when has to be set up to remember when has to wear them becarbis legs, she said that he refused to wear the foot/leg because of and she has let the information also. Further interview to 10:40 a.m., indicated that the resident had those his shave on Montime, that she was the resident on Mc CNA indicated that condition to the number of the current 3/11 hose. Another Phand on the current 9PAFO boot to rigoto be worn during the Broda chair.	steeth, she said, "he has esident who was still laying his conversation, then has not been given anything he also indicated that he obrush his teeth and cannot his teeth was last brushed. Cated that she has not put hall week because he refuses have they were too tight on she has let the nurse known has let the nurse known has he also indicated he has let the nurse known has he has not to his right of it being too tight as well, he nurse known that have a sware the he abrasions to his face after day. She indicated at that has not the CNA who shaved be conday after his shower. The tashe did not report the skin has either.		which systemic correction be completed 4/8/2011	ns will	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155469		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 03/14/2011		
		155469	B. WING	_		03/14/2	
NAME OF F	PROVIDER OR SUPPLIEF	2			DDRESS, CITY, STATE, ZIP CODE 49TH AVE		
SEBO'S		HABILITATION CENTER			T, IN46342		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PERCEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION) em. Review of the 3/11		TAG	DEFICIENCT)		DATE
	MAR, indicated th as being on the re off at night with no	e TED hose were signed out esident in the morning and odocumentation of refusals. Ited signature was for the					
	resident was at ris alteration in skin in failure, CHF, etc turn. The nursing skin clean and dry ADL care and for redness, bruising, and report to the r						
	3/8, and 3/9/11, for there was no docu	g Progress Notes, dated 3/7, or all three shifts indicated umentation regarding the ound his chin area or lower					
	updated on 12/11/ has broken, loose plan goal was that experience further approaches were oral cavity, teeth,	of care, dated 4/7/10 and 1/10, indicated the resident or carious teeth. The care the resident will not rooth decay. The nursing to assess the condition of tongue, lips, provide staff I hygiene, and obtain a					
	indicated she was obtained the abras cheek area from s indicated she was The LPN further in made aware the re	N #2 on 3/14/11 at 9:00 a.m., a unaware the resident had sions to his chin area and having on Monday. She is not informed of the areas. Indicated that she was not esident was refusing to e and PRAFO boot. The					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155469		A. BUILDING	CONSTRUCTION	(X3) DATE COMP. 03/14/2	LETED	
			B. WING STREE	T ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			W 49TH AVE		
SEBO'S	NURSING AND REI	HABILITATION CENTER	HOBA	ART, IN46342		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON .	(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	COMPLETION DATE
1710		had worked last Monday	17.0			Ditte
	and Wednesday a	nd was the regular floor				
	nurse during the d	lay on that hallway.				
	Interview with the	Assistant Director of				
		1 at 9:00 a.m., indicated the				
		e CNA were to inform the e resident refuses anything				
		e know if there was a				
		esident's skin integrity.				
	3.1-35(g)(2)					
	0.1 00(g)(2)					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETED
		155469	B. WIN			03/14/2011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			l	/ 49TH AVE	
SEBO'S I	NURSING AND REI	HABILITATION CENTER	HOBART, IN46342			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
F0309	Based on obse	rvation, record review,	F03	09	F309	04/08/2011
SS=D	and interviews,	the facility failed to				
00 D	provide the nec	essary care and			What corrective action(s) will be	II
	•	ure a resident who			accomplished for those resident	II
		ance with activities of			found to have been affected by t deficient practice;	ne
	•	transferred using the			dencient practice,	
	, ,	ue so that the resident			R121 is currently being transferre	ed
					with the use of the sit to stand	
	•	nce any pain for 1			mechanical lift. The CNA's	
	resident in the	•			responsible for completing that	
	(Resident #121)			transfer were immediately	
					re-inserviced when the facility wa	II
	Findings includ	e:			notified of the manual transfer. Ir	
					addition the physician will review	v the
	On 3/7/11 at 3:0	07 p.m., Resident #121			resident for additional pain	
	was interviewed	d. He indicated that staff			management.	
	do not listen to hir	n when he requests items.			How the facility will identify oth	
	The resident indic	ated staff do not always			residents having the potential to	II
	use the "lift" to tra	nsfer him from the bed to			affected by the same deficient	
		cated if the mechanical lift			practice and what corrective	
		uses him to have pain in			action will be taken;	
	his legs and feet.					
	On 3/10/11 at 10·4	0 a.m., CNA #1 entered the			All facility residents have the	
		ne CNA was asked how she			potential to be effected by the sar	me
		ent from the bed to the			alleged deficient practices.	
		ndicated that she transfers				
	him by herself or s	cometimes with the help of			Nursing staff has been re-inservio	ced
		ause he can stand and use			regarding the following:	
	•	indicated that she has			Use of care cards for transfers to ensure the correct transfer is	
		echanical lift for his			performed.	
		then left the room to get lp her get the resident out			Types of transfers, and conductin	σ
	of bed.	ap not get the resident out			safe transfers	0
	J. 500.				Notification of the charge nurse v	vith
	Interview with the	resident at that time, after			any complaint or observation of p	
		om, indicated he needed			such as facial grimacing.	
		to get out of bed, because				
	"it hurts my feet wl	nen I transfer from the bed			What measures will be put into	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

FJN011

Facility ID:

000366

If continuation sheet

Page 41 of 68

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155469		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/14/2011		
	PROVIDER OR SUPPLIER		B. WING GG/14/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN46342			
SEBO'S (X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIENT REGULATORY OR to the chair." The room with another the resident to the under his armpits position. The resi holding onto both was then observed his eyes were clost trying to move his backwards to the were then observed trying to move the The resident was chair. After being was then instructe himself backwards could reposition hi pushed down with armrests and push he did this, again a grimace, both of to be trembling as he grunted out lou backwards. Durin not help him. Interview with CNA p.m., indicated she resident's pain in I transfers to the ch indicated she was in his legs and fee from the bed to the know he has told o ok and other days The record for Re- on 3/9/11 at 11:00	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) CNA then came back to the CNA. Both CNAs pulled side of the bed and lifted and pulled him to a standing dent was able to stand while of the aides. The resident d grimacing with his face, sed while standing and while right and left legs chair. The resident's legs ed to be trembling while m towards the Broda chair. then seated into the Broda seated into the chair, he d by CNA #1 to push in the chair so that he imself. The resident then both of his hands on the ned himself backwards. As his face was observed with his legs were noted again he pushed downward and d while pushing himself g that time, both CNAs did A #1 on 3/10/11 at 12:10 e was then asked about the his legs and feet during the air from the bed, the CNA aware of the resident's pain at during those transfers e Broda chair, she stated, "I us that too, some days it is it is bad."			r; vill y y ors d on od li .; vill tee oths	
	kidney failure, cell	d but were not limited to, ulitis of bilateral lower estive heart failure, history of				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING				
		155469	B. WIN			03/14/20	JII	
NAME OF P	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE			
ecboie i	NI IDOING AND DEI	HABILITATION CENTER		1	7 49TH AVE			
SEBU S I				HOBAR	RT, IN46342			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE)		DATE	
	• •	ory of groin surgery, history y, cirrhosis of liver, alcohol						
		pressure, stroke, arthritis,						
	depression, and failure to thrive.							
	Review of the 12/1	11/10 quarterly Minimum						
		ssessment indicated the						
		rstood and able to						
		as alert and oriented times od or behaviors noted. The						
		lity was that he needed						
		ith two person physical						
		rs and he was totally						
	•	f for locomotion on and off						
	of the unit.							
	Review of the initia	al MDS assessment,						
	•	indicated the resident was						
		times three. The resident's						
		ed he needed extensive erson physical assist with						
	transfers.	erson priysical assist with						
		dication Administration						
	· · · · · · · · · · · · · · · · · · ·	the month of 3/11 indicated n order for acetaminophen						
		g) two tablets orally every 4						
	, ,	or pain. The medication						
		e time on 3/8/11 at 11:20						
	· .	complaints of generalized						
	pain.							
	Review of the care	e card that was inside the						
		oor indicated the resident						
	was limited assist	with all transfers.						
	Review of the Res	torative Nursing						
		pleted on 2/28/11, indicated						
	the resident was d	ependent on staff for ADL						
	care, bed mobility	and transfers.						

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION	r í	(X3) DATE SURVEY COMPLETED		
		155469	B. WING		03/14/	2011		
	PROVIDER OR SUPPLIER	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN46342					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
	3/10/11 at 11:40 a was receiving rest and active range of indicated the residual does not bear legs or feet) for tracketensive assist for to use the lift becard assessment for the card was inaccural. A new care card assessment for the completed by the 3/10/11. She indicated assistance with bracketensive with the p.m., on 3/10/11 in to use the Sara lift resident had told it.	s well as a new restorative e resident was then Restorative Nurse on ated the resident was to be						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155469			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE S COMPL 03/14/2	ETED
	PROVIDER OR SUPPLIER	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN46342				
SEBO'S (X4) ID PREFIX TAG F0312 SS=D	PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Based on observation, record review,		F03	HOBAR ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 312 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; R 121 was provided with set up assistance with oral hygiene and mouthwash and mouth swabs well provided. In addition the oral surgeon on 3/16/2011 saw the resident. How the facility will identify other residents having the potential is be affected by the same deficient practice and what corrective action will be taken; All facility residents who are	e s he re	(X5) COMPLETION DATE 04/08/2011
	a toothbrush in helps him. He time, they have but no one give he said, "The to teeth sometime with the resider not remember of member or him He said, "It was The resident fu not been offered.	e indicated there was the drawer, but no one also indicated at the the sponge swabs, is those to him to use, bothbrush hurts my s." Further interview int, indicated he does he last time, any staff self brushed his teeth. is a long time ago." rther indicated that he d mouthwash either. e resident was g in a Broda chair in his			dependent on staff to provide or assist in oral hygiene have the potential to be affected by the san deficient practice. An audit of residents who are dependent on st to provide some or all of oral care assistance was completed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur The DON/designee will conduct rounds 3x/weekly to observe that oral hygiene is completed. Nursing staff was in serviced on	taff	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

FJN011

Facility ID:

000366

If continuation sheet

Page 45 of 68

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		, DDIG		COMPL	ETED
		155469	1	LDING		03/14/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF I	PROVIDER OR SUPPLIE	₹					
050010	NUIDOINO AND DE	LIADU ITATION CENTED		1	/ 49TH AVE		
SEBO S	NURSING AND RE	HABILITATION CENTER		HOBAR	RT, IN46342		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	room. The res	ident's teeth were			4/1/2011 regarding the following	:	
	noted to be dis	colored, decayed and			Proper oral hygiene techniques		
	broken. The resident had many				Equipment needed and set up for		
	missing teeth				proper oral hygiene.		
					When to provide/ set up oral hyg	iene	
	On 3/9/11 at 9:40	a.m., the resident was in			How the corrective action(s)	/ill	
		the resident indicated his			How the corrective action(s) we be monitored to ensure the	/111	
		been brushed during the day			deficient practice will not recu	r.	
	or at night time.	g ,			i.e., what quality assurance	,	
					programs will be put into place	e;	
		40 a.m., CNA #1 entered the					
		sident out of bed for a			The DON/designee will complete	e	
		A was asked how often she			random interviews with 7 resider	nts	
	· ·	he resident and when does			weekly to ensure that oral care is		
		ident's teeth. She indicated			being completed and assistance i	S	
		he has not and does not			provided when needed.		
		all during morning care do it himself." The CNA					
		pedside drawer and there in			The DON/designee will present a		
		the resident's toothbrush in a			summary of the audits to the Qua	-	
	•	The toothbrush wrapper was			Assurance committee monthly for	r	
		at time, the resident was			three months. Thereafter, if		
		n the bed. The resident was			determined by the Quality Assura		
	then asked if the	CNA has ever given him a			committee, auditing and monitor	-	
		te to brush his teeth and he			will be done quarterly and preser quarterly at the QA meeting.	IL	
		ne CNA also indicated at the			Monitoring will be on going.		
		s not given him his			Wollitoring will be on going.		
		paste so he could brush his					
	· '	ne has bad teeth." The					
		still laying in the bed during then indicated that he has			Date by which systemic		
		lything to brush his teeth, he			corrections will be complete	d:	
	1	t he has to be set up to			April 8, 2011		
		nd cannot remember when			•		
	his teeth was last						
		sident #121 was reviewed					
		a.m. The resident's					
	1 -	ed but were not limited to,					
	kidney failure, cel	lulitis of bilateral lower					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DINC		COMPL	ETED
		155469	B. WIN			03/14/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			49TH AVE		
SEBO'S I	NITIDGING AND DE	HABILITATION CENTER			RT, IN46342		
366031	NORSING AND RE	HABILITATION CENTER		TIOBAN			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX	` ·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	S-REFERENCED TO THE APPROPRIATE	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		estive heart failure, history of					
		ory of groin surgery, history					
	of prostate surgery, cirrhosis of liver, alcohol abuse, high blood pressure, stroke, arthritis, depression, and failure to thrive.						
	Review of the 12/	11/10 quarterly Minimum					
		ssessment indicated the					
	resident was understood and able to						
		as alert and oriented times					
	three with no mod	od or behaviors noted. The					
	resident's ADL abi	ility was that he needed					
		ith a one person physical					
		ng and personal hygiene.					
		included combing the					
		d brushing his teeth, as well					
	as shaving.						
	Davious of the initi	al MDS assessment,					
		indicated the resident was					
	•	times three. The resident's					
		ed he needed extensive					
	-	al hygiene and required a					
		cal assist. The resident also					
		atural teeth missing and did					
	not have dentures	s. The resident had broken,					
	loose or carious to	eeth.					
	· ·	of care, dated 7/6/10 and					
	•	dicated the resident was					
		maintain grooming and					
		related to his physical ability. resident will be well					
		rsing approaches were to					
	_	notor function, sensation,					
		extremities, assess					
		e status, attitude toward					
	_	motivation in participate in					
	care and monitor						
	The current plan of	of care, dated 4/7/10 and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING		COMPL	ETED
		155469	B. WIN			03/14/2	011
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	t			49TH AVE		
SEBO'S	NURSING AND RE	HABILITATION CENTER			RT, IN46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	has broken, loose plan goal was that experience further approaches were oral cavity, teeth,	/10, indicated the resident or carious teeth. The care the resident will not rooth decay. The nursing to assess the condition of tongue, lips, provide staff I hygiene, and obtain a					
	indicated oral care completed 3/1-3/9 care was signed of the 3-11 shift on 3	Inflow sheet for 3/11 was signed out as being during the day shift. Oral but as being completed on 1/1, 3/2, and 3/7. The 1/2 had documented that they are on 3/10/11.					
		e card that was inside oor, indicated the resident ith grooming.					
	the resident was of care, bed mobility needed limited as face and extensive	storative Nursing pleted on 2/28/11, indicated dependent on staff for ADL and transfers. The resident sistance with bathing his e assist with bathing his equired set up with					
	3/10/11 at 11:40 a	Restorative Nurse on .m., indicated the resident's care card was					
	assessment for th completed by the 3/10/11. She indic	is well as a new restorative e resident was then Restorative Nurse on ated the resident needed e with brushing teeth and					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	COM	(X3) DATE SURVEY COMPLETED 03/14/2011	
	PROVIDER OR SUPPLIER	HABILITATION CENTER	4410 W	ADDRESS, CITY, STATE, ZIP CO 49TH AVE RT, IN46342	DE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	3.1-38(a)(3)(C)						

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) M A. BUII B. WIN	LDING G	ONSTRUCTION	(X3) DATE S COMPL 03/14/2	ETED
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE 7 49TH AVE		
SEBO'S I	NURSING AND REI	HABILITATION CENTER		HOBAR	RT, IN46342		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΤE	COMPLETION DATE
F0356	Based on obse	rvation and interview,	F03	56	F 356 What corrective		04/08/2011
F0356 SS=C	the facility failed sign at the begin at the begin everyday. The affect 119 reside the facility. Findings include: On 3/8/11 at 11:45 staffing sign was 3/7/11. On 3-11-11 at 11:05 staffing sign was proper area. Further date on the staffing earlier). Interview with the on 3/14/11 at 9:40 employee who was responsible for poeveryday. The Doscheduler had only Saturday and Sunthe time, that she is the sign at the sign at the beginning at the sign at the sign at the sign at the beginning at the sign at the beginning at the sign at	rvation and interview, d to post the staffing inning of each shift had the potential to ents who resided in sa.m. and 4:30 p.m. the observed posted on the wall of the facility. Further ted the date on the staffing so a.m. and 4:00 p.m., the posted on the wall in the er observation indicated the g sign was 3/9/11 (two days displayed). Director of Nursing (DoN) a.m., indicated another is the scheduler was sting the staffing sign on further indicated the y worked last Friday, day. The DoN indicated at was unaware the staffing sted at the beginning of each	F03	56	F 356 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The facility currently has nurse staffing dates sheets posted at the beginning the dayshift. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All facility residents have the have the potential to be affected by the deficient practice. The facility hired a new full time schedule who will be responsible for ensuring that daily the nurse staffing data will be posted at the beginning of the dayshift. An audit of nurse daily staffing sheets was completed to ensurthe facility has one for each day this month. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The scheduler will be responsible to ensure that daily the nurse staffing data will be posted at the beginning of the dayshift. Monday thru Friday the sched will post the nurse staffing data. On the weekends the reception will post the nurse staffing data.	ty tta g of ty nt ity r the ure ay the uler a. nist	04/08/2011
					In the absence of the schedule the Director of Nursing will ens the nurse datastaffing sheet is posted. The scheduler,	e sure	

T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE COMPI 03/14/2	LETED
PROVIDER OR SUPPLIER		4410 W	ADDRESS, CITY, STATE, ZIP CODE V 49TH AVE RT, IN46342	00/14/2	
NURSING AND RE SUMMARY S (EACH DEFICIEN		4410 W	/ 49TH AVE	f the phasis et eet at ft) will cur, ace; N/ sure ng nning a e ee ee, be	(X5) COMPLETION DATE

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE S COMPLI	
1 12.111	51 50142511011	155469	A. BUII			03/14/20	
		1.00100	B. WIN			00/14/20	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
SEDOIC I		LADII ITATION CENTED			/ 49TH AVE		
		HABILITATION CENTER		HOBAR	RT, IN46342		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	F02	TAG	F 371	+	DATE
F0371		rvation and interview,	F03	/1	F 3/1		04/08/2011
SS=E	•	d to ensure that 25 tray			What corrective action(s) will be	e	
		not stacked wet after			accomplished for those residents		
	_	This had the potential			found to have been affected by t	he	
		114 residents who were			deficient practice;		
	_	liets throughout the			The tone and the constant	1	
	facility.				The tray coverlids were complete dried before stored.	ly	
					and obtain stated.		
	Findings includ	e:					
					How the facility will identify oth	ier	
		:10 p.m., during the			residents having the potential to	be	
		ion Tour with the			affected by the same deficient		
		lanager, a rack of			practice and what corrective action will be taken;		
		s covered with plastic,			action will be taken,		
		n the corner of the			All facility residents who receive		
	kitchen. The pl	lastic cover had an			meal trays from the kitchen have		
	accumulation o	f condensation on the			potential to be affected by the san		
	inside. When u	ıncovered, 25 tray			deficient practice. The staff mem	ber	
	cover lids had b	peen stacked on top of			who incorrectly stored the tray		
	each other. Wh	nen lifted up, there was			covers lids was individually in serviced.		
	moisture betwe	en each lid.			Serviced.		
					What measures will be put into		
	Interview with t	he Dietary Food			place or what systemic changes		
	•	time, indicated the lids			will be made to ensure that the		
		e been stacked wet on			deficient practice does not recur	;	
	top of each oth	er.			The Food Service Manager/desig	nee	
					re-inserviced the dietary staff on	-	
	3.1-21(i)(3)				4/3/2011 regarding the importance	e of	
					ensuring that tray cover lids and		
					dishes are completely dried befor	e	
					being stored. The Food Service Manager/ designee will discuss w	ith	
					the dietary staff potential concern		
					when tray cover lids and other dis		
					are stored wet on top of each other		
FORM CMS-2	567(02-99) Previous Versio	ns Obsolete Event ID: F		Facility	ID: 000366 If continuation sl	neet Pac	ne 52 of 68

FJN011

Facility ID:

Page 52 of 68

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE	
NAME OF PROVIDER OR SUPPLIER 4410 W 49TH AVE	
SEBO'S NURSING AND REHABILITATION CENTER HOBART, IN46342	
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) PLETION ATE
How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; The Food Service Manager/designee will audit the lids to ensure they are direid completely before being stored at least weekly by and follow up with any concerns identified. The Food Service Manager/designee will present a summary of the audits to the Quality Assurance committee monthly for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: April 8, 2011	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 155469 03/14/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4410 W 49TH AVE SEBO'S NURSING AND REHABILITATION CENTER HOBART, IN46342 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE F0406 Based on observation, record review F0406 F 406 04/08/2011 and interview, the facility failed to SS=D What corrective action(s) will be ensure specialized communication accomplished for those residents rehabilitative services were provided found to have been affected by the for 1 of 3 residents with a diagnosis of deficient practice; mental retardation, in a sample of 39. R 3 was referred to speech therapy (Resident #3) on 3-11-11. Findings include: How the facility will identify other residents having the potential to be Resident #3 was observed on 3/11/11 affected by the same deficient at 7:15 a.m., eating breakfast. The practice and what corrective action will be taken; resident provided eye contact when spoken to, but did not respond All facility residents with a level two verbally. diagnosis have the potential to be affected by the same deficient Resident #3's record was reviewed on practice. The Social Service 3/11/11 at 9:00 a.m. The resident had Director and Alzheimer's Unit Director reviewed residents PAS/RR diagnoses that included, but were not paperwork to identify all facility limited to, cerebral palsy, mental residents that are currently a level retardation and seizure disorder. two and ensure recommendations are being followed. The Annual MDS (Minimum Data Set) What measures will be put into assessment with the assessment place or what systemic changes reference date of 2/19/11 indicated will be made to ensure that the the resident was rarely or never deficient practice does not recur; understood, rarely or never was able to understand and had no speech. The Social Service Director and Alzheimer's unit Director were re-in-serviced on 4/1/2011 regarding The plan of care, dated 2/25/11, the following: indicated the resident has difficulty PAS/RR recommendations understanding others and making self Specialized Communication Rehab understood related to mental Services. retardation and cerebral palsy

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	155469	A. BUI	LDING		03/14/2011
		133409	B. WIN			03/14/2011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	
SEBO'S	NURSING AND REI	HABILITATION CENTER			/ 49TH AVE RT, IN46342	
					t	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
	diagnosis.	220 1221111 1110 111 0111111111011	+		The Social Service Director and	5.112
	diagnosis.				Alzheimer's Unit Director will m	eet
	 The Δnnual Re	sident Review and			quarterly at the scheduled care pl	an
		dmission Screening			meeting to review residents PAS/	'RR
	,	Review) Nursing Facility			paperwork to ensure	
		mpleted 10/24/10, was			recommendations are being followed.	
	reviewed. One	•			TOHOWCU.	
		ons indicated: "It is				
		at (resident's name) be			How the corrective action(s) w	vill
	referred for a co	-			be monitored to ensure the	_
	evaluation and				deficient practice will not recur i.e., what quality assurance	,
	communication				programs will be put into place	e:
		training.				
	Review of the r	ecord indicated there			Quarterly the Administrator/	
		nication evaluation			designee will review five residen	ts'
	completed for t				records to ensure any recommendations on the PAS/RR	,
					paperwork is carried out.	
	Interview with L	PN #3 on 3/11/11 at				
		ated the resident can			The Administrator /designee will	
	•	answers or statements			present a summary of the audits t	
	such as "cold" i	f she is cold. She			the Quality Assurance committee	
	indicated the re	esident was not able to			monthly for three months.	
	verbalize comp	lete sentences.			Thereafter, if determined by the Quality Assurance committee,	
	'				auditing and monitoring will be d	lone
	Interview with T	The Alzheimer's Unit			quarterly and present quarterly at	
	Director on 3/1	1/11 at 10:05 a.m.,			QA meeting. Monitoring will be	on
	indicated the re	esident had not been			going.	
	referred to Spe	ech Therapy for a				
	· ·	evaluation or for			Date by which systemic	
	alternate comm	nunication training. The			corrections will be completed	d:
	Alzheimer's Un	it Director indicated the			April 8,2011	
	resident should	have been referred to				
	Speech Therap	y as recommended by				
	the Annual Res	ident Review.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CC A. BUILDING B. WING	JNSTRUCTION	COMP 03/14/2	LETED
	PROVIDER OR SUPPLIER		STREET A 4410 W	ADDRESS, CITY, STATE, ZIP O / 49TH AVE RT, IN46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	3.1-22(a)					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	DI 111	DDIC		COMPL	ETED
		155469	A. BUII			03/14/2	011
			B. WIN		ADDRESS CONT. STATE SID CODE		
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0550101		LABULTATION OF LITER			/ 49TH AVE		
SEBO'S I	NURSING AND REI	HABILITATION CENTER		I HOBAF	RT, IN46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0441		eview and interview, the	F04	41	F441 What corrective		04/08/2011
SS=E	,	ure tuberculin skin testing			action(s) will be accomplishe	ed	
33-E		or to employment for 2 of 5			for those residents found to		
		the last 120 days. This ad the potential to affect 119			have been affected by the		
	•	s residing in the facility.			deficient practice; No		
	(LPN #4 and CNA #				corrective actions can be mad		
	(El IVIII alla Olavii	,			for L.P.N. 4 and C.N.A. 5 Ho	w	
	Findings include:				the facility will identify other		
					residents having the potentia	ıl	
		tled "Tuberculosis, Employee			to be affected by the same		
		received from the Nurse			deficient practice and what		
		/11 at 10:40 a.m. The Nurse			corrective action will be take		
		ed the policy was current. evised date of April 2007. The			All facility staff have the poter	ntial	
		wly hired employees were to			to be affected by the same	~	
		(Tuberculosis) infections			deficient practice. The evenin shift supervisor audited all nev	-	
		in employment offer has been			hires this month to ensure that		
	made but prior to th	ne employee's duty			the employees TB test is		
	assignment.				administered after an		
	6 W	6 1			employment offer has been ma	ade	
		ee files were reviewed on			but prior to the employee's dut		
		n. LPN #4 was hired on documented TB (Tuberculin)			assignment. What measures		
		red to the LPN was on			will be put into place or what		
		as hired on 1/10/11. The			systemic changes will be ma	de	
		B skin test administered to			to ensure that the deficient		
	the CNA was on 1/2	24/11.			practice does not recur; The		
					facility designated the evening		
		on 3/14/11 at 10:45 a.m., the			shift supervisor in charge of th	e	
	-	ultant indicated the TB tests			staff TB program. The HR		
	hire for the above e	red prior to or at the time of			Director will ensure that the sta	ап	
	THE IOI LIE ADOVE E	inployees.			members first step TB is administered after an		
	When interviewed	on 3/14/11 at 11:50 a.m., the			employment offer has been ma	ade	
		or indicated the TB tests were			but prior to the employee's dut		
	·	rior to or at the time of hire for			assignment. The HR Director i	-	
	the above employe	es.			communicate to the evening s		
	0.4.44(4)(4)				supervisor weekly and provide		
	3.1-14(t)(1)				list of all newly hired staff. The		
					evening shift supervisor will		
					ensure that the first step TB is		
					read, the second step is		
			1		i		

	Γ OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CO A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/14/2011
	ROVIDER OR SUPPLIER	HABILITATION CENTER	4410 W	ADDRESS, CITY, STATE, ZIP CODE V 49TH AVE RT, IN46342	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BITTE
				completed, and the paperwork returned to the HR Director. Licensed nursing staff and the HR Director have been in serviced on the facility's system regarding obtaining newly his staffs tuberculin skin testing wemphasis given on the importance of administering to the importance of administering to the majolyee's duty assignment. How the corrective action(s) be monitored to ensure the deficient practice will not recuive., what quality assurance programs will be put into place the DON/designee will revier five newly hired staffs files a month to ensure that the TB was administered after an employment offer has been in but prior to the employee's diassignment. The DON/designity will present a summary of the audits to the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarter the QA meeting. Monitoring be on going. Date by which systemic corrections will be completed: April 8, 2011	eemee with hee offer ne will ur, we; w test made uty gnee eece ce

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETED
		155469	B. WIN			03/14/2011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER				/ 49TH AVE	
SEBO'S I	NURSING AND REI	HABILITATION CENTER			RT, IN46342	
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
F0465	Based on obse	rvation and interview,	F04	65	F 465	04/08/2011
SS=B	the facility failed	d to ensure a sanitary				
00 B	environment wa	as maintained in the			What corrective action(s) will be	l l
	kitchen related	to an accumulation of			accomplished for those residents	l l
					found to have been affected by t	ne
	dust and grease on fans and on top of ovens and steamers on 2 of 2 kitchen				deficient practice;	
		ith the potential to			The cover from the fan located no	ext
		y staff and 114 of 119			to the dish area and the tops of th	
		y stair and 114 or 119			ovens and steamers were cleaned	
	residents.					
	Findings includ	e:			How the facility will identify oth	ier
					residents having the potential to	be
	1. During the in	nitial Kitchen Sanitation			affected by the same deficient	
	Tour on 3/7/11	at 8:49 a.m., the fan			practice and what corrective	
		the dish area, had an			action will be taken;	
		f dust on the cover.			A 11 for ailite ann ai deantar and a marainn	
		he Dietary Food			All facility residents who receive foods and or fluids from the kitch	•
		•			have the potential to be affected by	
	_	time, indicated the fan			the same deficient practice.	, ,
	cover was in ne	eed of cleaning.			l list suite derivative produces.	
	O Dissilier at the 1	Citaban Canitation Town			What measures will be put into	
	_	Kitchen Sanitation Tour			place or what systemic changes	
		:10 p.m., with the			will be made to ensure that the	
	Dietary Food M	•			deficient practice does not recui	;
	accumulation o	f dust was observed			Th. F., 10., 11.	
	on top of the co	onvection oven. There			The Food Service Manager/desig	nee
	was also an ac	cumulation of dust on			re- inserviced the dietary staff on 4/3/2011 regarding the important	e of
	top of the stear	mer and the surface			following the cleaning schedule i	l l
	was sticky to to				order to keep the kitchen clean, d	l l
					free, and a sanitary environment.	
	Interview with t	he Dietary Food			Dietary staff will be instructed to	
		•			sign or initial the log when a duty	is
	_	time, indicated the top			complete.	
		on oven and the				
	steamer neede	d to be wiped down.				
					How the corrective action(s) w	ill

NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL) A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN46342 (X4) ID PROVIDER'S PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPL		OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	JNSTRUCTION	COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 3.1-19(f) 3.1-19(f) STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN46342 ID PROVIDERS PLAN OF CORRECTION COMPLETED TO THE APPROPRIATE DEVELLACY. TAG DEVELLACY. BE PROVIDER PRAYOF CORRECTION ACTION SIGNLE BE COMPLETED TO THE APPROPRIATE DEVELLACY. LIC., What quality assurance programs will be put into place; The Food Service Manager/designee will audit the kitchen at least weekly by and follow up with any concerns identified. The Food Service Manager/designee will present a summary of the audits to the Quality Assurance committee monthly for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed:							
SEBO'S NURSING AND REHABILITATION CENTER (X4) ID PREFIX TAG 3.1-19(f) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 3.1-19(f) Be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; The Food Service Manager/designee will audit the kitchen at least weekly by and follow up with any concerns identified. The Food Service Manager/designee will present a summary of the audits to the Quality Assurance committee monthly for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed:			<u>I</u>		ADDRESS, CITY, STATE, ZIP CODE		
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AND PLAN OF CORRECTION DENTIFICATION NUMBER: 155469 NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FO505 Based on record review and interview, the facility failed to promptly notify the resident's physician of abnormal ammonia level for 1 of 10 residents reviewed for unnecessary medications in the sample of 39. (Resident #121) Findings include: A. BUILDING D. SUMMARY STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN46342 STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN46342 STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN46342 STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN46342 STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN46342 STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN46342 ID PROVIDERS PLAN OF CORRECTION (S.5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF COMPLETE ON A SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CORRECTION SH	,
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reviewed for unnecessary medications in the sample of 39. (Resident #121) Control of the practice; R 1218 Physician was made aware of the ammonia level results. How the facility will identify other residents having the potential	
medications in the sample of 39. (Resident #121) medications in the sample of 39. ammonia level results. How the facility will identify other residents having the potential	
(Resident #121) the facility will identify other residents having the potential	
residents having the potential	
Eindings include: to be attented by the came	
· · · · · · · · · · · · · · ·	
deficient practice and what	
The record for Resident #121 was reviewed corrective action will be taken;	
on 3/9/11 at 11:00 a.m. Review of the laboratory results indicated an ammonia All residents who have orders for labs to be drawn outside the	
level was completed on 3/4/11 at 7:34 a.m., at facility at the hospital have the	
the hospital. The ammonia level reading was potential to be affected by the	
189 a high result (11-55) normal. The results same deficient practice. The	
were completed on 3/4/11 at 8:52 a.m. licensed nurse who cared for R	
121 when returned from his	
Review of Physician orders, dated 3/7/11, ammonia level lab draw from the	
indicated another ammonia level was to be hospital was in serviced	
done on 3/11/11 at the hospital. Review of the individually on the importance of	
bottom of lab page indicated "MD (physician) obtaining and reporting the	
aware at 10:00 a.m., new orders received." ammonia level results timely and	
documenting the lab results/	
Interview with LPN #1 on 3/14/11 at 12 p.m., physician response in the nurses	
indicated that she did not notify the resident's notes. What measures will be	
physician until 3/7/11 of the abnormal put into place or what systemic ammonia level. She also indicated the labs	
results could have been obtained on 3/4/11 by changes will be made to ensure that the deficient	
calling the hospital lab.	
A.D.O.N. has developed a	
Interview with the Assistant Director of calendar to follow up on residents	
Nursing (ADoN) on 3/10/11 at 8:08 a.m., with orders for labs drawn outside	
indicated since the lab was done at the the facility at the hospital to	
hospital nursing staff needed to call the ensure the lab results are	
hospital and get the results. She indicated the obtained and reported to the	
hospital does not fax the facility the results physician timely. Licensed	
and it was the nurse's responsibility to call the nursing staff were in serviced on	
hospital and get the results. The ADoN indicated her expectations for nurses were to the importance of: · obtaining lab results drawn outside the facility	
results drawn outside the facility	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
	∥ 155469 						03/14/2011	
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN46342					
	NURSING AND REF SUMMARY S' (EACH DEFICIEN REGULATORY OR		B. WIN	STREET A	49TH AVE	ent ng ab ill , ; 5 the d will ts or ee, ate ns	(X5) COMPLETION DATE	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
155469		B. WING			03/14/2011		
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				/ 49TH AVE		
SEBO'S	NURSING AND REI	HABILITATION CENTER		· ·	RT, IN46342		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
F0514	Based on obse	rvation, record review	F 514 What corrective			_	04/08/2011
SS=D	and interview, t	he facility failed to			action(s) will be accomplished	∌d	
-	maintain clinica	al records that were			for those residents found to		
	complete and a	accurately documented			have been affected by the	ath	
	-	mentation of a skin			deficient practice; R 48's Ba and Skin Report Sheet reflects		
	rash for 1 of 3 r	residents who met the			has a rash. How the facility		
		pressure related skin			will identify other residents		
		e sample of 39.			having the potential to be		
	(Resident #48)	•			affected by the same deficier	nt	
	(Resident #40)				practice and what corrective		
					action will be taken; Any		
	Findings includ	e:			resident who has a rash has th	ne	
					potential to be affected by the		
	On 3/8/11 at 1:	55 p.m. and 3:45 p.m.,			same deficient practice.		
	Resident #48 w	as observed to have a			Immediately, the ADON in serviced staff when made awa		
	red rash to his	face, arms and back of			An audit was completed to	iie.	
	neck.				identify other residents with		
					rashes. What measures will	be	
	On 3/9/11 at 8:	30 a.m., 10:55 a.m.,			put into place or what systen	nic	
		the resident's face and			changes will be made to		
	· ·	erved to have a red			ensure that the deficient		
	discoloration.	cived to have a red			practice does not recur;		
	discoloration.				Nursing staff was in serviced of		
	The same and four	D = -!-			how to complete the Bath and		
		Resident #48 was			Skin Report Sheet with empha given to:	ISIS	
		8/11 at 2:01 p.m. A			ensuring skin conditions that		
		er dated 11/12/09 and			continue such as a rash remai	ins	
	listed on the 3/11 Physician's Order				documented on		
	Summary, indic	cated the resident was			accurate documentation.		
	to have Triam	0.1% cream applied			Ensuring the Bath and Skin		
	twice daily to the affected areas.				Report Sheet is reflective of th	ie	
					resident, residents' current		
	The 2/24/11 Co	emprehensive Skin			treatment orders and residents	5	
		dicated no areas of			plan of care. How the corrective action(s)	will	
	breakdown wer				be monitored to ensure the	VV 111	
					deficient practice will not recur	۲,	
		nent for rash over body.			i.e., what quality assurance		
			1				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
155469		A. BUILDING			03/14/2011		
		133409	B. WIN			03/14/20	J11
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
SFBO'S	NURSING AND REI	HABILITATION CENTER		1	/ 49TH AVE RT, IN46342		
					075)		
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TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	A plan of care, the resident had legs, and arms. Review of 3/11 Administration of indicated the Traigned out twice. Review of the Easheets for the mon 3/1, 3/3, and skin was documentated the sheets and/or Skin report she 2/11 indicated the intact on 2/3, 2/2/21, 2/24, and no documentated in the sheets of the motes, dated 3/1 indicated treatments, and the sheets of the motes, dated 3/1 indicated treatments, rash of the sheets of the motes, dated 3/1 indicated treatments, rash of the sheets of the sheets of the motes, dated 3/1 indicated treatments, rash of the sheets o	dated 3/7/11, indicated d a rash to the back, Treatment Record (TAR), riam cream had been e daily for the month. Bath and Skin report month of 3/11 indicated d 3/7/11 the resident's mented as being intact. documentation of a rash. The Bath and ets for the month of the resident's skin was (7, 2/10, 2/14, 2/17, 2/28/11. There was ion of redness or a			programs will be put into place The DON/designee will audit 1 residents' bath sheets weekly complete and accurate documentation. A summary of the audits will be presented to Quality Assurance committee monthly by the DON/designee three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarte at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: April 8, 2011	0 for if the for	

II		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING		COMPLETED		
		155469	B. WING		03/14/2011	
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
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PREFIX	`	CY MUST BE PERCEDED BY FULL				
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
		the resident's skin				
		onth of March 2011,				
		ne resident's skin was				
	_	intact. She stated the				
		ve a rash and redness				
	_	ing and maybe that				
	was why it was	not documented.				
	Interview with t	he ADON on 3/10/11 at				
		icated there was no				
		n how to complete the				
		er sheets. She further				
		resident had an				
		ondition such as a rash				
	and/or redness					
		the skin and shower				
	sheet.					
	0110011					
	3.1-50(a)(1)					
	3.1-50(a)(2)					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
155469		A. BUILDING			03/14/2011		
100.100			B. WING			03/14/2011	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE V 49TH AVE		
SEBO'S NURSING AND REHABILITATION CENTER					RT, IN46342		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION	(X	5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		
TAG		LSC IDENTIFYING INFORMATION)			DEFICIENCY)	DAT	
F9999	STATE FINDING	GS	F9999		F 9999		/2011
F9999	hours in subsection regular contact was minimum if six (dementia-specific months of initial thirty (30) days for the Alzheimer's a unit, and three (3) thereafter to meet preferences, or be impaired residents of the current star residents with detection. This state rule was by: Based on record facility failed to (3) hours of demonstrates was provided and the state of the current star residents.	the required inservice on (1), staff who have with residents shall have a 6) hours of a training within six (6) employment, or within for personnel assigned to and dementia special care 1) hours annually at the needs or oth, of cognitively at the gain understanding and and soft care for mentia. The service wand interview, the consure the required three entials specific training anually for 19 of 88 required annual in-service (19)	F99	99	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The facility has conducted the required hours of dementia training for the identified employees. How the facility will identify other residents having the potential to affected by the same deficient practice and what corrective action will be taken; All facility residents have the potential to be affected by the same alleged deficient practice. There were no additional employees identified that have not completed the required training. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recurrent. The Human Resource Director/designee will keep an ongoing audit of current employe and their current total of hours of dementia training. The Human Resource Director will ensure that newly hired employees will received in the side of the surface of the	he lg er be l ;; es t ve	/2011
	The facility files	for Dementia training of			completing orientation. The Alzheimer's Director/ designee w		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	155469		B. WING		03/14/2011		
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN46342				
(X4) ID PREFIX TAG	employees were 9:00 a.m. The form of receive three specific training Employee #1- H 6/0/09 Employee #2- A 1/4/08 Employee #3- L Employee #4- C Employee #5- L Employee #6- C Employee #7- C Employee #7- C Employee #10- Employee #10- Employee #11- Employee #11- Employee #12- Employee #13- Employee #14- on 10/12/09 Employee #15- Employee #16- 8/30/00 Employee #17- hired on 4/24/09 Employee #18- Employee #18- Employee #19- 5/6/09 When interviewee	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) reviewed on 3/14/11 at following employees did hours of dementia during 2010. Tousekeeper hired on ctivity Aide hired on PN hired on 6/29/09 NA hired on 9/23/09 PN hired on 11/30/05 NA hired on 5/22/96 NA hired on 10/8/08 N hired on 8/27/09 NA hired on 9/23/09 CNA hired on 7/22/09 CNA hired on 11/16/09 RN hired on 11/4/09 CNA hired on 8/4/99 Restorative Nurse hired LPN hired on 3/4/09 Dietary Manager hired on Maintenance Supervisor CNA hired on 11/28/08 Dietary Aide hired on	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD IT CROSS-REFERENCED TO THE APPROP DEFICIENCY) conduct additional dementia to at least quarterly. How the corrective action(s) be monitored to ensure the deficient practice will not redice, what quality assurance programs will be put into play the Administrator designee we review 5 employees' records into ensure that the required train completed. The Administrator/designee we present a summary of the audit the Quality Assurance committed the Quality Assurance committed, auditing and monitoring will be quarterly and present quarterly QA meeting. Monitoring will going. Date by which systemic corrections will be completed. Date by which systemic corrections will be completed.	aining O will O will Cur, ace; rill conthly ning is ill is to tee e e done at the be on	N	

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155469			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE COMPI 03/14/2	LETED
	PROVIDER OR SUPPLIER	HABILITATION CENTER	4410 V	ADDRESS, CITY, STATE, ZIP CODE V 49TH AVE RT, IN46342	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE	
1	regulatory or employees did no	ot receive the required rs of dementia specific		CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	